CRACKING THE CODES

MEDICAID RESPONSE TO THE LOCAL CODE DILEMMA

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The HIPAA final rule of August 17, 2000 dealt Medicaid agencies a monumental blow. For years we had been encouraged to develop new services while continually being required to report such services in ever changing ways. The answer had always been to develop a local code that would pay the service correctly, pull funding from the proper account, and appropriately log the service for reporting purposes. For many states, the list of local codes had grown proportionately to their creativity in providing services or their budgetary requirements. In some cases states had thousands of locally developed codes to process the majority of their business. Loss of these codes would significantly handicap Medicaid's ability to provide and report healthcare services to those with significant medical need.

The National Medicaid EDI HIPAA Workgroup, NMEH for short, took on the challenge presented by the local codes issue. In a series of meetings, the workgroup developed solutions that have been recognized by the entire healthcare industry as a model. The process has not, however, been painless or simple. Within the process, states have learned much about the HIPAA standards, how their systems operate, where to find expertise, and mostly, the art of compromise.

ASSESSMENT

The first step in the process was to determine when and why local codes were being used. In a brainstorming session, states listed the reasons that local codes had been developed and how they were being used. That list became the framework from which to explore solutions to the problems presented:

- Tracking, accounting, counting and reporting
- Reimbursement – quick, easy, automated, consistent
- Ability to add new services quickly
- Funding sources and program reporting
    - Ties to recipients – such as waivers for certain services
    - Providers specific to certain services as a way of restricting or controlling
- Local codes established location of the service
- Units of service might be different from national codes
- Codes addressed regulations – both state and federal
    - Legislative mandates
    - Court orders
- Paper and electronic process were disparate
- Definition of national codes is either too generic or too specific

The assessment also included looking carefully at the processes necessary to move forward. What was the scope of the local codes problem? Were CPT codes an option to use? What was the process for requesting HCPCS codes? Would that process be sufficiently responsive to meet

the huge needs presented? How could we work together to avoid duplication of effort and present a more unified, forceful voice?

THE PLAN

The answers to some of our assessment questions came with assistance provided by a representative from HCFA (now CMS). He assured the group that HCFA was committed to working with Medicaid agencies to develop solutions. He agreed that the timelines for submissions for HCPCS codes would not suffice in the HIPAA world and committed to moving the request and acceptance process along more quickly. He also collaborated with the AMA regarding the CPT codes and assured the group that CPT codes could be used for any professional service and that modifiers for HCPCS would be interchangeable with those for CPT. These assurances motivated the group to move forward.

The scope of the problem was daunting. States were asked to evaluate their existing codes to look for matches to the national code list and develop a listing of codes that could not be "crosswalked" to an existing standard code and to leave off codes that would be taken care of by other HIPAA changes. It was estimated that there were at least 50,000 local codes nationwide. States had compiled their local codes and had submitted them to New York to be aggregated into a single list. That list—with only about 30 states submitting—numbered over 30,000. The codes themselves were not always of the same format and often had abbreviations or local designations that made them particularly unique. The task seemed overwhelming. Additionally, HCFA reflected that there would only be 9999 code spaces available for all special payer types including VA, Medicaid, DOD, etc. and their expectation was that Medicaid would reduce their list to about 2000 or less.

With that expectation, the local codes workgroup sent the list back to the states to be reworked again. Their instruction to each state was, "do your homework." Each state was to look at their submitted codes and weed out any that had other solutions. A list of helpful hints was returned to each state:

- Avoid using local codes to define specific provider or provider classifications
- Crosswalk any code that has a national code that is comparable—we will not get codes that have acceptable alternatives
- Attempt to find other data content combinations to solve special payment and reporting needs, such as provider taxonomy, units, modifiers, place of service
- Look to creative use of CPT codes
- Look to the implementation guides to determine if you can get the information elsewhere on the claim
- Explore the use of the "note" field or the "K" field to obtain certain types of information
- Determine what information will come in on attachments.

When the states had completed their refinement process, the codes were again accumulated for the workgroup. This time, the total count was about 18,000.

ANOTHER GROUP MEETING

A cursory look through the new list identified some basic problems. Though states had submitted their codes under a set list of categories, it was clear that the definition of those categories might differ from state to state. For instance, many states might pay for nursing time in their Home and Community Based Services Waiver program. Some states would have submitted those codes under the category of "nursing" while other states would have submitted under the "waiver" category. California agreed to take the aggregated list from all of the states and develop a word search that would more accurately group the codes. That way, all codes reflecting "nursing" would be considered at the same time, not by program.

With the newly categorized list in hand, the local codes workgroup again met in a face to face meeting in Baltimore. The group divided itself into nine sub-workgroups that each took one or more categories of codes to work through. A group decision was made that all codes should be crosswalked, but that each state would always maintain the prerogative of choosing another acceptable crosswalk or submitting a request for a code to meet their needs. Representatives at the meeting also needed to develop a thick skin regarding the work they were about to do. At no time would they please everybody and they were really to develop codes that would work for the greatest number of payers—necessitating a more generic approach. Thought was also given to not attaching a unit identifier to the code, such as, "nursing service—15 minutes" as there was a unit indicator in the 837 format. Since that would leave the definition of units up to trading partner agreements and could differ from one state to another, it was determined that keeping units in the code would make it more standard for the industry.

SLICING, DICING, AND CHOPPING

Each sub-workgroup began by loading the full category into an Excel spreadsheet. Then each group conducted a cursory scan of the codes within the category looking for recurring themes. This would be similar to a key word search, however the theme might include several words or phrases. A list was made of obvious recurring themes so these could be worked individually. The computer program was used to conduct a search for the first recurring theme. When each search produced a list of codes with that theme, the group would work through the list to see which were exact duplicates, and which were very similar. Codes might be very similar, except they might differ in time units or might carry some location identifier particular to that state. Out of the list with this theme, the workgroup would develop one or more generic codes that incorporated the majority of requirements from the list. In some cases, the workgroup developed a generic code as well as one or more modifiers that would address the state differences. Newly proposed codes were listed under a numbering system that would not duplicate any numbers from the group as a whole. This process was continued until the list of recurring themes had been exhausted. What remained was a short list of codes that had not appeared as part of a recurring theme, either because the codes were unrelated or because they did not use the same language as the theme. If they could fit into any new code already developed, they were added to the list under that code.

At this point, the groups had a large list of codes that had been crosswalked to newer, generic codes developed to accommodate the needs. What remained was a list of codes that did not

seem to fit nicely into the developed boxes. The workgroups then attempted to fit these outlier codes into any existing HCPCS or CPT codes. If the code would fit with some modifications, the workgroup then proposed changes to existing HCPCS codes. In some cases, an existing code could have a single word added and accommodate a number of local codes. For instance, some transportation codes might list only busses, trains, or taxis. The addition of the word "subway" or "ferries" might allow for transportation mechanisms particular to certain parts of the country. Finally, the group looked at these outlier codes to determine if they belonged in another category. While the key word search might have placed the code in this category, the essence of the code might better fit under some other program. Services such as "day treatment" seemed to occur in a variety of categories.

Throughout this process, the group reconvened occasionally to discuss problems, celebrate progress, and redistribute outlier codes. It was also apparent that the work could not be completed during this two-day meeting, so plans were made for continuation of the work at home.

Once at home, the subworkgroups continued their efforts and communicated occasionally by conference call and e-mail. For any outlier codes that defied explanation, that state was contacted for clarification. For any codes that seemed particular to only one or very few states, discussions were held regarding the necessity of pursuing that code further or finding other places in the 837 to obtain the information. Finally, newly developed codes needed strong business cases to make them viable candidates for acceptance as national codes. Our HCFA representative also proved very helpful to understand the need for the code and to explain how HCFA would analyze the request. Continual refinement of the business case helped reinforce the fact that no other alternative would be acceptable and that this code was critical to the business of Medicaid.

When all the crosswalks had been developed and the business cases written, the work product was shared via the NMEH LISTSERV to all states. States were free to comment, protest, request, recommend, and modify the work of each small group. This process brought in all the states that had not participated in the work process and helped solidify the final recommendations that would move upward to HCFA.

The final leg of the process was to submit the codes, modifiers, and requested code changes to HCFA along with a substantial business case for the request. The HCPCS panel within HCFA had agreed to meet monthly to consider the influx of Medicaid codes being requested. If approved by this committee, the code would be established as a "temporary" code. Though states were concerned by the "temporary" status, they recognized that many temporary codes had existed for years. If it is necessary to change a temporary code, HCFA also provides a crosswalk to newly developed codes, so no code would simply vanish. The list of "temporary" codes approved by this committee would be published quarterly which would also speed up the process of converting from local codes. The first group of Medicaid codes was accepted by HCFA in January of 2001.

Although not all of the codes have been submitted to CMS for final approval, the work of the local codes workgroup continues. The list of over 30,000 codes has been reduced to less than

500 codes and modifiers. The process should be completed early in 2002, although the process of developing and requesting new codes will be ongoing.

LESSONS LEARNED

Many hands make light work. This has always been true, but never was it so apparent as in this process. Without collective ideas, questions, and even disagreements, the end product would not be as good as it is. The process of sharing reimbursement mechanisms, program elements, and service descriptions has strengthened every Medicaid agency in its effort to provide the best services to its clients and the most accountability to the taxpayers.

Leave no stone unturned. The need to face scrutiny from a large variety of parties forced the workgroup to be very diligent about being sure there were no other alternatives that would meet the needs presented by a particular local code. If data could be obtained from somewhere else in the transaction, that would be necessary to do. All committee members became intimately acquainted with the intricacies of the HIPAA transactions.

Necessity is the mother of inventions. If there had been an unlimited supply of code numbers, there would likely have been many more codes suggested. The mandate from HCFA to reduce to fewer than 2000 meant we really needed to embrace the concept of administrative simplification. When we began to think more nationally, it was easier to develop truly generic codes that had more applicability to more states and services.

There is a light at the end of the tunnel. Perhaps it is some help from federal partners, perhaps it is expertise shared with others, or perhaps it is simply necessity. It is possible to accomplish what seems to be impossible. What is more, the end product may actually be superior to the sum of the parts.